



# HOSPITAL REPORT FOR PERINATAL HEPATITIS B PREVENTION

Follow-up of infants born to HBsAg positive mothers

Please complete the form with as much information as possible and FAX to the Perinatal Hepatitis B Prevention Program at **1-877-427-7318**.

<b>For Women Known to be HBsAg Positive:</b> <input type="checkbox"/> Administer hepatitis B immune globulin (HBIG) and hepatitis B vaccine within 12 hours of births to all infants.  If the infant doesn't receive HBIG within 12 hours, it can be administered up to 7 days after birth.	<b>For Women Whose HBsAg Status is Unknown:</b> <input type="checkbox"/> Perform a stat HBsAg screening test for all women admitted to delivery whose hepatitis B status is unknown.  <input type="checkbox"/> While test results pending, administer the hepatitis B vaccine to infant within 12 hours of birth. If the mother is discovered to be HBsAg positive then administer HBIG as soon as possible and within 12 hours of birth.
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HOSPITAL NAME \_\_\_\_\_ CITY \_\_\_\_\_

TODAY'S DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## MOTHER'S INFORMATION

Last Name: _____		First Name: _____	
Date of Birth: ____ / ____ / ____		HBsAg positive test date: ____ / ____ / ____	
Address: _____			
City: _____		Zip Code: _____	
Contact Phone #: ( ) _____		Alternative Phone #: ( ) _____	
OB/GYN Name: _____		OB/GYN Phone #: ( ) _____	
Race: (check all that apply) <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian		<input type="checkbox"/> Caucasian or White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Race, not otherwise specified	
		Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No	

## INFANT'S INFORMATION

Last Name: _____		First Name: _____	
Date of Birth: ____ / ____ / ____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of HBIG: ____ / ____ / ____		Date of Hepatitis B1 vaccine: ____ / ____ / ____	
Pediatrician's Name _____		Pediatrician's Phone #: ( ) _____	
<b>IMPORTANT:</b> Clinic where infant will receive Hepatitis B2 vaccine: _____ Note: Hepatitis B2 vaccine is recommended at 1 month of age.			

For questions or more information please call (785) 296-8156.

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